REQUEST FOR RESTRICTION ON USE OR DISCLOSURE OF HEALTH INFORMATION

THE OREGON CLINIC

Please send this form to:

The Oregon Clinic Medical Records Department (ATTN: Clinical Content Manager) by:
FAX: (503) 935-8404 or **E-MAIL***: compliance@orclinic.com or **MAIL**: 541 NE 20th Ave. Ste. 225, Portland, OR 97232
Communications via e-mail are not secure

PART A: INDIVIDUAL TO COMPLETE (please print):

Name (last, first, middle): _____

Date of Birth: _____ Telephone No.: _____

Address: _____

Medical Record No.: _____

REQUEST:

I request that The Oregon Clinic (TOC) restrict the use or disclosure of health information in the following manner:

Please specify the type of health information and the requested restriction:

_____

_____

Please identify the specific TOC service area/division or department to which this restriction applies:

_____

ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION:

I understand that TOC does not have to agree with my requested restriction(s). If TOC agrees to this request, the restriction is effective (unless emergency situations require otherwise) until one of the following events occurs:

- I agree to, or request, that the restrictions be terminated; or
- TOC notifies me in writing that they are terminating restriction, and in this case the termination is effective only as to information created or maintained after I am notified of the termination.

Documentation about an acceptance or denial of a request for restriction is maintained at TOC's Compliance and Privacy Officer and can be obtained by contacting compliance@orclinic.com or (503) 963-2806.

Patient or Legal Representative signature: _____

Print Name of Legal Representative (if applicable): _____

Date: _____

PART B: ALL REQUESTS SHALL BE FORWARDED TO THE HIPAA SPECIALIST OR PRIVACY OFFICER FOR REVIEW:

Request for restriction is: ☐ accepted ☐ denied

Staff comments:

_____

_____

_____

Signature of staff: _____

Name/Title: _____

Date: _____